# United States Department of Labor
# Employees' Compensation Appeals Board

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| **B.M., claiming as widow of H.M., Appellant** | ) | |
| **and** | ) | **Docket No. 20-0741** |
| | ) | **Issued: September 30, 2021** |
| **DEPARTMENT OF THE NAVY, NAVAL AIR SYSTEMS COMMAND, Patuxent River, MD, Employer** | ) | |

*Appearances:*
*Appellant, pro se*
*Office of Solicitor,* for the Director

*Case Submitted on the Record*

## DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

### *JURISDICTION*

On February 18, 2020 appellant filed a timely appeal from an August 22, 2019 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

### *ISSUE*

The issue is whether appellant has met her burden of proof to establish that the employee's death on January 23, 2017 was causally related to his accepted employment conditions.

### *FACTUAL HISTORY*

On January 26, 1978 the employee, then a 37-year-old aircraft pneudraulic systems mechanic, filed an occupational disease claim (Form CA-2) alleging that he sustained a heart attack

[1] 5 U.S.C. § 8101 *et seq*.

on September 11, 1977 due to stress from performing his employment duties. On May 7, 1986 OWCP accepted his claim for acute myocardial infarction of the anterolateral wall and generalized anxiety disorder. It paid the employee wage-loss compensation, which began after his myocardial infarction.[2] The employee returned to work in a part-time position as a security guard in November 1985 and stopped work on May 12, 1986. OWCP paid him wage-loss compensation commencing May 13, 1986.[3]

In September 2000 OWCP expanded the acceptance of the employee's accepted conditions to include other complication due to other cardiac device, implant, and graft. In October 2008 it authorized an automatic implantable cardioverter-defibrillator device for the employee.

On January 25, 2017 appellant, the employee's widow, advised OWCP that the employee passed away on January 23, 2017. She submitted a marriage certificate and a death certificate, which listed the causes of death as ventricular tachycardia arrest and acute non-ST elevation myocardial infarction.

On March 15, 2017 appellant filed a claim for compensation by widow (Form CA-5) in her capacity as widow of the deceased employee in which she alleged that the employee's accepted stress-related myocardial infarction contributed to his death. Under item 3 on the "attending physician's report" portion of the form, Dr. Douglas Epperson, a Board-certified internist, listed the "history of injury or employment[-]related disease given to [appellant]" as "heart attack, cardiomyopathy related to stressful job." He indicated that the employee had been treated for ischemic cardiomyopathy with failure, and opined that the direct cause of death was ventricular tachycardia arrest and the contributory causes of death were ischemic cardiomyopathy and heart failure. Dr. Epperson checked a box marked "Yes" to indicate that the employee's death was due to the conditions listed in item 3.[4]

Appellant submitted a March 2, 2017 report from Dr. Epperson who noted that the employee had been a patient of his since 2001 and advised that he had severe ischemic cardiomyopathy with symptomatic heart failure. Dr. Epperson reported that the employee had ongoing angina and symptoms of ischemic disease, which were disabling and opined that, in the end, the causes of his death were acute myocardial infarction and complications due to automatic implantable cardioverter-defibrillator device. He indicated that patients who suffer from a myocardial infarction develop an adverse neurohormonal response that leads to a progressive decline in global ventricular function. Dr. Epperson advised that, therefore, a patient with a small infarct progresses to have a global cardiomyopathy over the course of years to decades. He asserted that, at the time of the employee's myocardial infarction in 1977, this mechanism of injury was not understood. Dr. Epperson noted, "There is no doubt that [employee's] progressive cardiomyopathy and eventual death was due to his … coronary artery disease and historical

[2] The employee retired from the employing establishment on May 5, 1978. The record reveals that the employee was employed at Naval Air Rework Facility, Naval Air Station Alameda, Alameda, California and that this facility is closed.

[3] The employee did not work after May 13, 1986.

[4] Dr. Epperson signed his report on March 10, 2017, although he inadvertently identified the report as having been completed in January 2017, rather than March 2017.

myocardial infarction." Appellant also submitted an unsigned document regarding the employee's medications after a hospital admission in early-2017, discharge date January 6, 2017, as well as diagnostic tests results and treatment reports from 2015 and 2016. The treatment reports contained multiple diagnoses including ischemic cardiomyopathy, heart failure, ventricular tachycardia, diabetes, and sleep apnea.

OWCP referred the case, including a recent statement of accepted facts (SOAF), to Dr. Amanda Trimpey, a Board-certified occupational medicine specialist serving as an OWCP district medical adviser (DMA). It requested that Dr. Trimpey review the opinion of Dr. Epperson and provide an opinion regarding whether the employee's death was employment related.

In a September 14, 2017 report, Dr. Trimpey discussed the employee's employment and medical histories and listed the accepted employment conditions. She indicated that there were no documents in the case record dated after the document regarding the employee's hospitalization in early-January 2017, discharge date January 6, 2017, such as hospital records from on or near the date of his death. Dr. Trimpey detailed Dr. Epperson's March 2, 2017 report and opined that it was "in disagreement" with a February 7, 2015 report of Dr. Raye Bellinger, a Board-certified internist and cardiologist who had previously served as a DMA. She indicated that Dr. Bellinger advised in that report that the employee's cardiac conditions, including cardiomyopathy, progressive coronary artery disease, and congestive heart failure were not related to the 2017 myocardial infarction. Dr. Trimpey asserted that OWCP had "accepted this expert opinion" because the SOAF did not list any updated accepted conditions, such as cardiomyopathy or recurrent myocardial infarction. She advised that, to definitively complete her review of the case, additional medical documents were needed, particularly those produced from mid-2016 until the employee's death on January 23, 2017.

Numerous additional documents were added to the record, most of which were authored between mid-2016 and the employee's death on January 23, 2017. On November 30, 2017 OWCP requested that Dr. Trimpey review the additional evidence and submit a supplemental report in her capacity as DMA.

In a December 29, 2017 report, Dr. Trimpey indicated that she had reviewed the medical evidence recently added to the case record. She indicated that Dr. Bellinger, the previous DMA, had opined in January 26, 2011 and February 7, 2015 reports that the employee's multiple hospitalizations for myocardial infarction, congestive heart failure, and global cardiomyopathy were not related to his accepted 1977 myocardial infarction. Dr. Trimpey noted that Dr. Bellinger had determined that the employee's January 2017 hospital admission was nonindustrial in nature because the myocardial infarction sustained at that time "was not/could not be determined and there was no evidence of involvement the anterolateral wall, the accepted condition of the [employee]." She advised that the most recent SOAF did not indicate that the employee's case had been accepted for congestive heart failure, sub-endocardial infarction, or coronary artherosclerosis. Dr. Trimpey noted, "[a]s the progression of the [employee's] cardiac conditions, as listed above, have been previously determined as nonindustrial, and not accepted as work related, his death in 2017 was also, nonindustrial in nature."

By decision dated January 10, 2018, OWCP denied appellant's claim for survivor's benefits. It found that the weight of the medical opinion evidence rested with Dr. Trimpey who

found that the employee's January 23, 2017 death was not causally related to his accepted employment conditions.

On February 5, 2018 appellant requested a review of the written record by a representative of OWCP's Branch of Hearings and Review. She submitted numerous additional medical documents produced between 2008 and 2016.[5]

Appellant also submitted a February 1, 2018 report from Dr. Dana Weisshaar, a Board-certified cardiologist, who indicated that appellant advised her that her survivor's benefits claim had been denied because the medical record failed to establish that the employee's death from ventricular tachycardia and heart failure was caused by his accepted 1977 myocardial infarction of the anterolateral wall. Dr. Weisshaar noted, "I find this conclusion completely puzzling." She indicated that the natural history of a myocardial infarction was for it to lead to progressive deterioration of heart function, ischemic cardiomyopathy, over time. Dr. Weisshaar advised that advances in medical therapy have allowed physicians to postpone the development of this sequela, but not to eradicate it. She reported that the employee presented to her care when his heart failure symptoms, as a result of his ischemic cardiomyopathy, had become advanced. Dr. Weisshaar opined that, ultimately, despite medical therapy for heart failure, the employee succumbed to cardiogenic shock and ventricular tachycardia. She indicated, "[t]hese were direct sequelae from his underlying heart disease[,] which began in 1977 with the anterior wall myocardial infarction."

By decision dated May 25, 2018, OWCP's hearing representative affirmed the January 10, 2018 decision.

On April 16, 2019 appellant requested reconsideration of the May 25, 2018 decision. She submitted medical evidence authored between 1978 and 1987, as well as a July 17, 2010 hospital discharge summary and a copy of Dr. Weisshaar's previously submitted February 1, 2018 report.

By decision dated May 1, 2019, OWCP denied appellant's request for reconsideration of the merits of his claim pursuant to 5 U.S.C. § 8128(a).

On May 24, 2019 appellant again requested reconsideration of the May 25, 2018 decision and submitted medical evidence. By decision dated August 22, 2019, OWCP denied modification of the May 25, 2018 decision.

## ***LEGAL PRECEDENT***

The United States shall pay compensation for the disability or death of an employee resulting from personal injury sustained while in the performance of duty.[6] An award of compensation in a survivor's claim may not be based on surmise, conjecture, or speculation or on appellant's belief that the employee's death was caused, precipitated, or aggravated by the

[5] Appellant submitted a November 14, 2016 report from Dr. David I. Krohn, a Board-certified internist previously serving as a DMA, who indicated that the employee's November 22, 2015 hospital admission was related to his accepted 1977 myocardial infarction.

[6] 5 U.S.C. § 8133 (compensation in case of death).

employment.[7] Appellant has the burden of proof to establish by the weight of the reliable, probative, and substantial medical evidence that the employee's death was causally related to an employment injury or to factors of his or her federal employment. As part of this burden, appellant must submit a rationalized medical opinion, based upon a complete and accurate factual and medical background, showing a causal relationship between the employee's death and an employment injury or factors of his or her federal employment. Causal relationship is a medical issue and can be established only by medical evidence.[8] The mere showing that an employee was receiving compensation for total disability at the time of his or her death does not establish that the employee's death was causally related to the previous employment.[9] The Board has held that it is not necessary that there is a significant contribution of employment factors to establish causal relationship.[10] If the employment contributed to the employee's death, then causal relationship is established.[11]

Section 8123(a) of FECA provides that if there is a disagreement between the physician making the examination for the United States and the physician of an employee, the Secretary shall appoint a third physician (known as a referee physician or impartial medical specialist) who shall make an examination.[12] For a conflict to arise, the opposing physicians' opinions must be of virtually equal weight and rationale.[13]

## ***ANALYSIS***

The Board finds that this case is not in posture for decision.

There is a conflict in the medical opinion evidence between the attending physicians, Dr. Epperson and Dr. Weishaar, and OWCP's DMA, Dr. Trimpey regarding whether the employee's January 23, 2017 death was employment related.

In a March 2, 2017 report, Dr. Epperson reported that the employee had ongoing angina and symptoms of ischemic disease, which were disabling and opined that, in the end, the causes of his death were acute myocardial infarction and complications due to automatic implantable cardioverter-defibrillator device. He indicated that patients who suffer from a myocardial infarction, such as the employee, develop an adverse neurohormonal response that leads to a progressive decline in global ventricular function. Dr. Epperson advised that, therefore, a patient

[7] *W.C.*, Docket No. 18-0531 (issued November 1, 2018).

[8] *See R.G. (K.G.)*, Docket No. 19-1059 (issued July 28, 2020); *L.R. (E.R.)*, 58 ECAB 369 (2007).

[9] *P.G. (J.G.)*, Docket No. 20-0815 (issued December 10, 2020); *Edna M. Davis (Kenneth L. Davis)*, 42 ECAB 728 (1991).

[10] *See P.G. (J.G.), id; T.H. (M.H.)*, Docket No. 12-1018 (issued November 2, 2012).

[11] *Id*.

[12] 5 U.S.C. § 8123(a); *see E.L.*, Docket No. 20-0944 (issued August 30, 2021); *R.S.*, Docket No. 10-1704 (issued May 13, 2011); *S.T.*, Docket No. 08-1675 (issued May 4, 2009); *M.S.*, 58 ECAB 328 (2007).

[13] *P.R.*, Docket No. 18-0022 (issued April 9, 2018).

with a small infarct progresses to have a global cardiomyopathy over the course of years to decades. He noted, "There is no doubt that [the employee's] progressive cardiomyopathy and eventual death was due to his … coronary artery disease and historical myocardial infarction." In a February 1, 2018 report, Dr. Weisshaar indicated that the natural history of a myocardial infarction was for it to lead to progressive deterioration of heart function, ischemic cardiomyopathy, over time. She advised that advances in medical therapy have allowed physicians to postpone the development of this sequela, but not to eradicate it. Dr. Weisshaar reported that appellant was presented to her care when his heart failure symptoms, as a result of his ischemic cardiomyopathy, had become advanced. She opined that, ultimately, despite medical therapy for heart failure, the employee succumbed to cardiogenic shock and ventricular tachycardia. Dr. Weisshaar indicated, "These were direct sequelae from his underlying heart disease, which began in 1977 with the anterior wall myocardial infarction."

In contrast, Dr. Trimpey indicated in a December 29, 2017 report that Dr. Bellinger, the previous DMA, had opined in January 26, 2011 and February 7, 2015 reports that the employee's multiple hospitalizations for myocardial infarction, congestive heart failure, and global cardiomyopathy were not related to his accepted 1977 myocardial infarction. She noted that Dr. Bellinger had determined that the employee's January 2017 hospital admission was non-industrial in nature because the myocardial infarction sustained at that time "was not/could not be determined and there was no evidence of involvement the anterolateral wall, the accepted condition of the [employee]." Dr. Trimpey advised that the most recent SOAF did not indicate that the employee's case had been accepted for congestive heart failure, sub-endocardial infarction, or coronary artherosclerosis. She noted, "[a]s the progression of the [employee's] cardiac conditions, as listed above, have been previously determined as nonindustrial, and not accepted as work related, his death in 2017 was also, nonindustrial in nature."

Because there remains an unresolved conflict in medical opinion regarding whether the employee's January 23, 2017 death was causally related to his accepted employment conditions, pursuant to 5 U.S.C. § 8123(a), the case will be remanded to OWCP, together with the medical record and a statement of accepted facts, to an appropriate specialist for an impartial medical examination to resolve this issue. After such further development as OWCP deems necessary, it shall issue a *de novo* decision.

## ***CONCLUSION***

The Board finds that this case is not in posture for decision.

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the August 22, 2019 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded to OWCP for further proceedings consistent with this decision of the Board.

Issued: September 30, 2021
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

Janice B. Askin, Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board